mount**hermon** | redwood canopy tours

Adult Participant Agreement

IT IS MANDATORY THAT THIS FORM BE READ, FILLED OUT, SIGNED AND DATED BY THOSE 18 YEARS OF AGE AND OLDER WHO WISH TO USE THE MOUNT HERMON CANOPY TOUR.

I, the undersigned, use the Canopy Tour at Mount Hermon with full knowledge that I accept full responsibility for any injury or accident that may occur.

I do agree to hold harmless the Mount Hermon Association and their employees, for any and all claims for injuries, causes for action, or liability related to use of the Canopy Tour .

Although the Mount Hermon Association has taken reasonable steps to provide appropriate equipment and skilled employees so that you can participate in activities for which you may not be skilled, we now remind you that the Canopy Tour is not without risk. Certain risks cannot be eliminated without destroying the unique character of this activity. The same elements that contribute to the character of this activity can be causes of loss or damage to your property, accidental injury or illness, or, in extreme cases, permanent trauma or death. This form is not intended to frighten you or reduce your enthusiasm for this activity, but it is important for you to be informed and know in advance about the inherent risks.

In case of medical emergency, I give permission to the physician selected by the Camp Administration of the Mount Hermon Association to hospitalize, secure proper treatment for, and/or to order injection, anesthesia or surgery for myself. Should medical services become necessary, the expenses are my sole responsibility as the participant.

I hereby agree to permit the Mount Hermon Association employees or agents to take photographs and/or video and make film records of the activities and me without further recourse. I understand and agree that such photographs and/or video may be used for commercial and/or promotional purposes.

I have read and voluntarily agree to participate on the Canopy Tour at the Mount Hermon Association, and I sign this agreement.

TOUR DAY/DATE: _____TOUR TIME: _____

NAME: _____ BIRTHDATE_____

DRUG ALLERGIES OR ALLERGIC REACTIONS:_____

_____

RELEVANT MEDICAL CONDITIONS _____

_____

SIGNATURE _____ DATE SIGNED_____